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Thematic analysis of mechanisms underpinning email peer support for young people with eating disorders

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Abstract

Purpose – Peer support, such as mentorship and befriending, have been found to have a valuable impact on a range of outcomes. There are multiple formats, including face-to-face (individually and group); and in online forums. Advancement in technology has enabled online peer support to increase in popularity, however little is known about mechanisms underpinning individual one to one online peer interactions. The purpose of this paper is to qualitatively explore the mechanisms underpinning email exchanges in an eating disorder peer support service.

Design/methodology/approach – Email transcripts from dyads in a moderated peer to peer email support service were analysed using inductive thematic analysis (Braun and Clarke, 2006).

Findings – The thematic analysis generated five themes as mechanisms of peer support. *Relating and Reflecting experience* was the central superordinate theme. Subthemes included *Positive Encouragement*, *Checking in and Prompting*, *Being a Confidante* and *Defining Recovery*.

Originality/value – The current findings align with previous research and add new developments. The theme of *Defining Recovery* added the awareness of the personal perception of recovery, which had not been considered as a mechanism in previous literature and may be specific to this digital platform. The study could assist in the development of training for the provision of further peer support within eating disorder services.

Introduction

It is estimated that approximately 1.25 million people in the UK have an eating disorder (ED) (Beat, 2018). About 15% of people with an ED meet criteria for Anorexia Nervosa, with most individuals presenting with Bulimia Nervosa, Binge Eating Disorder, or Other Specified Feeding and Eating Disorders (OSFED) (NICE, 2017). Across this diagnostic spectrum, a wide range of disordered eating behaviours can be present including restriction, bingeing, vomiting and excessive exercise. This can lead to significant medical complications, reduced quality of life and psychological distress (Klump *et al.*, 2009).

The importance of social relationships in the maintenance of health and wellbeing is well recognised. Levine (2012) conducted a systematic review and found that a number of ED diagnoses specifically correlate to loneliness, and qualitative studies have outlined the importance of an individual's perceived social support on the trajectory of, and recovery from an ED (Linville *et al.*, 2012). Peer support, including peer befriending and mentorship programmes, has been used as adjunct intervention in the wider health literature. The World Health Organisation (2017) defines these services as “people coming together affected by a similar concern so they can explore solutions to overcome shared challenges and feel supported by others who have had similar experiences and who may better understand each other's situation,”. Though there is often overlap in terminology, the universal feature is the provision of support and guidance shared between individuals with a similar lived experience, often between a more recovered or experienced individual with someone at an earlier stage in their recovery (Shalaby *et al.*, 2020; Brown *et al.*, 2007). Peer support been found to have a valuable impact on a range of outcomes including quality of life (Fuhr *et al.*, 2014); improved medical outcomes (Ljungberg *et al.*, 2010); and also been shown to reduce rehospitalisations in patients with multiple psychiatric admissions (Sledge *et al.*, 2011).

A number of successful peer support approaches have been developed for individuals with EDs that have been effective in reducing symptoms, body dissatisfaction and improving quality of life (Beveridge *et al.*, 2019; Hanly *et al.*, 2020; Perez *et al.*, 2014; Ramjan *et al.*, 2017; Ramjan *et al.*, 2018; Ranzenhofer *et al.*, 2020). In Beveridge's (2019) qualitative evaluation of their structured face to face mentorship programme, mentees reported benefiting from improved hope and motivation, an increase in agency in managing their recovery and described the support as collaborative with an equal dynamic between themselves and the mentor that was unlike clinical treatment (Beveridge *et al.*, 2019). However, relatively little research attention has focused on the incorporation of peer support into treatment plans for people with eating disorders (Beveridge *et al.*, 2019), or the impact on service use. One preliminary study of a peer mentorship programme found individuals matched with a peer mentor missed fewer appointments with treatment providers compared to unmatched mentees (Perez *et al.*, 2014), but further research is required in this area.

More recently, advancements in technology have enabled online peer support approaches to mental health (e.g. open or closed forums, social media, emails etc.) to increase in popularity (Fortuna *et al.*, 2019). Online peer support may provide advantages over traditional health care including high levels of anonymity, availability regardless of time or location, immediate access, and the potential of such support to be seen as less stigmatising (Bauer and Moessner, 2013; Gulliver *et al.*, 2010). Furthermore, online peer support has the potential to offer particular advantages for individuals with EDs, for example by reducing opportunities for body comparisons which may take place in face-to-face groups (Walstrom, 2000). Various studies have examined the support provided in online support groups for people with EDs

(Kendal *et al.*, 2016; Winzelberg, 1997) and the groups are reported to provide individuals with informational support (Eichhorn, 2008), a safe space and flexible support (Kendal *et al.*, 2016). Hastings and colleagues (2016) examined an online support group for diabulimia, an eating disorder presentation related to insulin omission in individuals with type 1 diabetes, which was reported to reduce loneliness, create a means to assist symptom management and facilitate shared learning. The participants in the groups stated they were able to talk honestly about their experiences in a way they felt uncomfortable doing with their healthcare professionals. Email exchange services are a commonly provided online peer support platform for individuals with EDs. Yet, while interactions on online group forums have been analysed using qualitative methodologies (Eichhorn, 2008), parallel research has not been conducted on peer support correspondence in email exchanges. There are implementation differences in these digital mediums, where email messages can span a longer time frame than online support groups, and are more private, an important consideration when we know individuals experiencing higher levels of social anxiety may increase their self-disclosure in private online settings, compared with more public online settings (Green *et al.*, 2016). Therefore, the digital medium may have an impact on the type of interactions and communication taking place during online peer support.

To develop supportive peer-based approaches which assist in recovery, it is important to understand the mechanisms underlying them (Watson, 2017). In the peer support literature, a key underpinning theory is Social Learning Theory (SLT), which states that individuals acquire behaviours from others who they consider to be like themselves (Bandura, 1977). Those being supported are thought to model behaviours from their supporter resulting in them feeling more confident in managing their difficulties and empowered in their future (Davidson *et al.*, 2012). SLT has been used as the theoretical basis for a range of peer support

programmes of diverse service structure and presentations (Boisvert *et al.*, 2008; Sadler *et al.*, 2017). Within the field of EDs, it is hypothesised that matching individuals with similar characteristics who are in recovery from an ED may assist those attempting to overcome their disordered eating. However, this is based on the assumption of upward social comparison (Festinger, 1954) (evaluating oneself against those perceived to be superior on a given dimension) and omits consideration of the potential detrimental impact of downward comparison, where an individual evaluates themselves against those perceived to be less fortunate e.g. a peer supporter whose experience is more severe or far removed from their own, in an attempt to make themselves feel better. This highlights the need for research exploring the underpinning mechanisms of peer support within the field of eating disorders; alongside further quantitative research exploring the impact of peer support, including potential negative impact. In addition, it is important to note that most research exploring mechanisms of support are derived from face to face programmes rather than online platforms (Watson, 2017). It is imperative to explore the mechanisms present in online platforms to guide further forms of peer support aligned with service user preference and the need to develop effective training.

The present study aims to address the gaps identified by exploring the mechanisms of the peer support in email exchanges for young people, aged between 14 and 25 years old, experiencing an ED. The study intends to understand the mechanisms used to provide peer support in a moderated email service for young people with EDs. The email correspondence was explored using inductive thematic analysis and conclusions regarding the mechanisms were drawn from the findings.

Methods

Ethical approval was obtained from the University of Edinburgh. The study was registered with the NHS Lothian Quality Improvement Team and approval was given by Beat, the national ED charity in the UK.

Participant information sheets about the aim of the study were distributed to all those engaging in the peer support service by Beat prior to informed individual consent for 14-25 year olds. The identity of the participants was protected through the use of anonymous identifiers which were used for the transcripts and stored separately to any potentially identifiable information. Beat removed any recognisable information, such as names, location and health services from the transcripts prior to analysis.

Participants and procedures

This study analysed archival email transcripts, accumulated during participation in an online peer support programme. All individuals that signed up to engage in a peer-to-peer email support service facilitated by Beat, in partnership with NHS Lothian CAMHS, were invited to take part in this study. The peer support service was funded by a Scottish Government Technology Enabled Care Grant. The support service was available to anyone between 14 and 25 years of age who self-identified as experiencing an ED in Scotland. The inclusion criteria were left relatively open to improve access to the service but the presence of an eating disorder was verbally confirmed with the Beat peer support coordinator. Once they made contact with Beat, the Young Person (YP) was matched with a Peer Befriender (PB); a volunteer between the age of 18 and 35 who has been in recovery (self-identified) for at least 2 years. The PBs were trained by Beat prior to being paired with a YP. The pairs were matched according to similar diagnoses and experiences. Up to three emails a week were

exchanged, with all emails being sent to a Beat email address and moderated for any potentially inappropriate content before being sent on.

On completion of the peer support, participants were invited to take part in the qualitative email analysis study and to consent to their email exchanges to be analysed. They were provided with information regarding the use of their data and asked to provide informed consent if they were willing for their email data to be used. Both members of a pairing needed to provide consent for their email exchanges to be used.

Of 23 dyads invited to take part, three pairings consented to their email exchanges being analysed. The YPs within these three pairings were between the ages of 21 and 25 years old, were all female and two were engaged with services. Two of the participants self identified as presenting with Anorexia Nervosa and one with Bulimia Nervosa.

The method of inductive thematic analysis was adopted, which does not dictate a set sample size and instead focuses on the depth of analysis (Braun and Clarke, 2006). An inductive approach was used due to the novelty of the project. The transcripts were compiled from a year's worth of email exchanges between the pairings. Transcript 1 consisted of 35 emails (14,830 words); Transcript 2 was 29 emails (6989 words); and Transcript 3 was 35 emails (33,902 words).

Data Analysis

A contextualist approach was assumed with the inductive thematic analysis (Braun and Clarke, 2006; Madill *et al.*, 2000). The contextualist theoretical underpinning appreciates the

reality of the dyads experience alongside the acknowledgement of the wider social context and the impact of researcher's understanding of theory (Braun & Clarke, 2006; Madill *et al.*, 2000). It prompted the researchers to be aware of their experiences as female psychologists working within an eating disorder CAMHS team, whilst recognising the context and situation of the pairing held within peer support dynamic. An inductive analysis was employed owing to the novelty of the type of data and to ensure that the analysis was driven by the data, rather than a deductive approach shaped by pre-existing theory on peer support mechanisms.

The six stages of thematic analysis described by Braun and Clarke (2006) were applied to the data. This involved firstly familiarisation with the data and then generating initial codes. The researchers organised the codes into initial themes separately, which were then reviewed and discussed together. Finally, the researchers defined and named each of the themes and subthemes concluding the analysis in the following results write up.

Results

The inductive thematic analysis (Braun and Clarke, 2006) of the email transcripts outlined a superordinate theme of *Relating and Reflecting Experience* along with subordinate themes including *Positive Encouragement*, *Being a Confidante*, *Checking in and Prompting* and *Defining Recovery* (Figure 1.).

[Insert Figure 1 here.]

Relating and Reflecting Experience

Through analysis of the email exchanges, it appeared as though the PBs used their shared experience with the YPs as the foundation of their support. It formed the common ground between them and the vehicle for other mechanisms of support. Peer support functioned by

the dyad being able to relate their experiences to each other. All three PBs compared the YPs current problems to their own narratives and provided them with reassurance.

I'm so glad you shared your experience about having to make your surroundings perfect before you eat X. I hope it comforts you to hear that I was the exact same way. I don't want to go into details, but I also had a lot of unhealthy little obsessions about the cutlery I used, the crumbs on the worksurfaces etc before I had a meal. I was speaking to my mum about this the other night and she said it was one of the first things she noticed that made her realise I wasn't just a girl on a diet, but rather my eating was starting to adversely affect my life. (PB, Transcript 3)

The three PBs were able to draw comparisons between their experiences and reassure the YPs their behaviours were related to the ED and were not abnormal within the context of its symptoms. The comparing of experiences appeared to be a method of demonstrating to the YPs that they are not alone in having struggled with ED behaviours. Each of the PBs presented their own vulnerabilities and personal experience to the YPs they were paired with. The drawing of commonality appeared to build a rapport and an open platform for sharing.

In addition, through relating their experience, each of the PBs were able to reflect on their experiences. They were able to provide suggestions and guidance from their consideration of what had assisted them in their recovery.

From my own experience, I am very aware that I need to actively work to stay healthy (physically and mentally) because of where I have been in the past with anorexia. But from talking to friends and helping them with their problems, I sometimes think my issues in the

past have given me a toolkit which a lot of my “healthy” friends lack - and I feel I have a mental robustness which was gained through overcoming my illness. (PB, Transcript 3)

Each of the PBs contemplated their recovery and what they gained from their experience with an ED. The PBs felt they had self-awareness and a resilience which enabled them to help others and their reflections on their success in recovery demonstrated a sense of pride in what they had overcome. The purpose of this appears to have been to inspire the YPs to continue with their recovery.

Positive Encouragement

All of the PBs remained a positive force throughout the email exchanges, highlighting improvements in the YPs progress and providing messages of encouragement. One of their main tools for emphasising positivity was holding a mirror up to the YP’s progress.

I think it’s obvious even from just reading your emails that you have made significant progress since May. I’m so pleased to hear you think your tendencies to mirror and body check have lessened too. Those are the kind of behaviours that really take a toll and drain you of the energy you need in recovery, so good job on working on that! (PB, Transcript 3)

The three PBs expressed their pride in the YPs and highlighted their positive steps forward in recovery, encouraging the YPs through providing positive reinforcement. The PBs were able to acknowledge the difficulties that the YPs had had to contend with by drawing parallels with their own experience with an ED.

You definitely have a persistence and a toughness about you and I know you can do it!

Trying a food or drink that scares you once a week is a great idea! Even on holiday, you're keeping at your recovery. That's very admirable. Well done. (PB, Transcript 1)

Reading your email reminded me all too well of my own struggle - the vicious cycle of binging/restricting is absolutely exhausting and it's easy to feel like things will never get better, especially when you're feeling so low. But I know recovery is possible for you and you're working so hard to fight this (plus, you're far stronger than I ever was, so if I can do it, I know you can too!). (PB, Transcript 1)

In the above example, the PB reiterated their own experience to remind the YP that as they were able to overcome the behaviours, the YP would too. The PB commented on the YP strengths outside of the ED in an effort to make them feel valued.

Being a Confidante

Each of the PBs were able to build a dynamic where the YPs could confide with them. By relating their experience, the PBs attempted to create a space in which the YPs felt comfortable sharing the challenges they were facing. The YPs used the service to discuss their ED thoughts, relationships and current challenges. The PBs reassured them and responded non-judgementally by sharing similarities in their own experience.

Honestly X, I could have wrote that whole paragraph of your email about uni back when I was a student. (PB, Transcript 3)

The quote above documents a PB's response to a YP's disclosure. The PB reassured the YP by sharing that they had a similar experience in their recovery, normalising the YP's behaviour, with the potential aim of encouraging them to continue to share their problems.

Being at home is stressful and a lot of control has been taken away from me. It is making me stubborn at meal times and I'm trying to find new ways to eat as few calories as possible. I guess I'm trying to find ways to break the rules that they won't notice I'm doing. I get a strange sense of satisfaction in doing so... (YP, Transcript 1)

I'm sorry to hear you're having a hard time at home - that sounds like a tough dynamic, especially as you're struggling with your eating. (PB, Transcript 1)

The quotes outlined above presents an example of a YP describing their struggles, and the PB responding with empathy. The YPs were able to discuss their ED behaviours and thoughts with someone with similar experience, therefore understands the disorder and associated behaviours. The YPs were able to discuss sensitive areas of their life, such as their family as demonstrated below.

Home is simply there to meet the need of putting a roof over my head and giving me dinner. I need to remember that it's not home that will meet my emotional needs but that can be okay because I do have other spaces that do that. I just get sad sometimes that my relationship with my mum isn't how I'd like it to be. (YP, Transcript 1)

The YPs expressed their challenges in managing recovery. As the PBs could relate to their experience, the YPs were supported to vocalise how they were managing recovery and challenging their ED.

I've still been finding those voices hard. I feel like I not only have to fight the anorexia voice but also the binge voice and I'm really struggling to find the energy to fight it. I end up in cycles of binging and restricting depending on what voice I give into. All I want is my own, healthy voice to be able to speak through. I think I'm really scared that I'll never have a healthy relationship with food. (YP, Transcript 1)

The YPs often described struggling with the ED voice and cognitions. In one pairing, the YP and PB named the ED voice the 'Demon' (Transcript 3). The YP spoke about their complex relationship with ED and its impact on their life. Together, the PB and YP discussed the difficulties of managing recovery and separating from their ED.

Eating disorders can be so incredibly lonely, but I have felt less alone because I have been able to talk to you. (YP, Transcript 2)

The YP reported to benefit from having someone to discuss their problems as it reduced their sense of loneliness as demonstrated in the quote above.

Checking in and Prompting

During email correspondence, all three PBs asked the YPs about their progress and prompted them to engage in health seeking behaviours. For some YPs, this created accountability to the

PBs. Whilst checking in, each of the PBs made practical suggestions, promoted engagement with services and the use of an emotional toolkit, all whilst drawing on their own experience.

The accountability one of the YPs felt toward the PBs is demonstrated in the following quote. The YP relied on peer support as a means of accountability and highlighted the importance of having an individual to be accountable to, who could monitor them.

Overarching support and accountability is the main thing I'm missing. It means I can be control in unhelpful ways and can manipulate the accountability I do have to not eat. (YP, Transcript 1)

In addition, each of the PBs would use checking in as a mechanism to promote engagement with services. Through relaying their own positive experiences, they were able to guide the YPs towards engaging.

A few weeks ago you mentioned that you will be receiving support from your local ED unit and that you'll begin seeing a psychologist - I'm not sure if you've met with anyone yet but if you have, I hope everything went well. One thing I forgot to ask - will you be receiving support from a nutritionist? I think this is a huge thing that helped me, so perhaps it could help you too. (PB, Transcript 1)

Their questioning gave them a route to offer and make suggestions based on their experiences. They provided strategies from their own experience, such as developing an emotional toolkit, learning a new hobby or using their support network when feeling distressed.

I know you're struggling with lack of routine at the moment - would you consider joining a course or working somewhere else part-time? I find sometimes learning a new skill gives me something to focus on and it becomes a positive energy outlet. Is there anything you've been wanting to learn like painting or floristry or something else? (PB, Transcript 1)

These suggestions would range from practical advice, to tips which could be used in a crisis.

Defining Recovery

Through matching and comparing experiences, two of the pairs were able to form their own definition of recovery. The PBs would outline their experience and how they conceptualised recovery. Their definitions would focus on the relationships they had to their body and food, whereas the YPs tended to focus on weight and BMI. The PBs would attempt to redirect them towards a psychological and more holistic model of recovery.

For me, recovered means your weight is no longer a priority - your life is a rich one and what you eat and how you exercise are things that further enrich your life, they aren't causes of stress or anxiety, and they certainly aren't shackles that hold you back from living your best life. (PB, Transcript 3)

The PB in the quote above claims recovery as personal and not set by a medicalised definition. They highlighted the impact of removing the 'shackles' of their ED. The PB focuses on the 'enrichment' of life, rather than the erasure of symptoms. The pair would discuss recovery, envisaging it as a journey rather than a set point.

That's the thing about recovery, there's no distinct rungs on the ladder. I probably went back and forth a lot during recovery, even after reaching a healthy weight, but the important thing is that I was generally heading in the right direction. You will almost certainly have relapses like that too X, and it's nothing to get down about. You need to just be kind to yourself when it happens and get back on track afterwards. As we have discussed before, we are in for a long-term deal here - anorexia is something we'll always have to be wary of. As you keep working at recovery however, each relapse will be shorter and less frequent. (PB, Transcript 3)

In the quote above, the PB described their relapses and normalises them as part of a recovery process, presented recovery as more attainable. Furthermore, all the YPs were able to explore the concept and process of recovery by asking details about the PBs' personal experience.

Have you experienced these thoughts of relapse before? How did you cope/get through them? (YP, Transcript 1)

Did you find that you had a desire to restrict again after you had reached a healthy weight, or did you find that you were able to maintain a healthy diet free from restriction without too much of a problem? (YP, Transcript 3)

Did you worry about what people (particularly family) would think once they saw you healthier and no longer anxious round about food? (YP, Transcript 3)

Each of the YPs asked about the process of recovery and the PBs responded with descriptions of their experience, a dynamic which would be impossible to achieve with a mental health

professional. Defining recovery in one's own terms, is a form of support and empowerment. All the PBs encouraged YPs to engage with their own recovery and supported them in doing so by exemplifying their own version of recovery.

Discussion

These findings align with previous literature on underpinning mechanisms in a range of peer support mediums, including the central component of experiential knowledge and the reciprocity, but also present a novel mechanism within email peer support conceptualised as Defining Recovery.

Defining Recovery was gradually developed during email exchanges where the dyads formed their own definition of recovery from an ED. Clinical recovery criteria can include factors such as weight stabilisation and achieving a healthy BMI, which can be challenging for those trying to distance themselves from focusing on weight (Malson *et al.*, 2011). The peer dyad navigated the potential detrimental focus on weight by creating personalised versions of recovery criteria consisting of individualised goals, beyond merely living without ED symptoms. This aligns with Bradstreet's (2006) approach which emphasises a holistic sense of recovery than standard criteria, with it being described as a journey rather than the absence of symptoms. Bradstreet (2006) noted that the benefit of this includes an active engagement in treatment, the promotion of self-management, the development of coping strategies and generation of hope and optimism. Furthermore, the dyads discussed relapse as part of a recovery process, which is helpful for those who may be demotivated when faced with relapse (Malson *et al.*, 2011).

The formation of a personalised recovery definition has not previously been identified within qualitative analysis of peer support groups and forums therefore may be specific to the medium of one to one peer support email exchanges. Online forums and support groups rely on shorter interactions with potentially less opportunity to develop these discussions (Wesemann and Grunwald, 2008). The use of extended email exchanges over a prolonged period of time may have exposed the YPs to a richer account of the PBs' experiences and provided more potential for safe reflection to define personal recovery.

A fundamental finding aligned with previous literature was that shared experience provided a foundation that facilitated other support mechanisms, where PBs communicated and used their experiential knowledge to facilitate the peer support process. Watson (2017) conceptualised the Use of Lived Experience which details using personal experience to provide support both explicitly, to earn credibility amongst those individuals were supporting (Austin *et al.*, 2014; Mourra *et al.*, 2014), and implicitly to explain what was helpful in recovery (Austin *et al.*, 2014; Watson, 2017). This process, underpinned by SLT, was clearly demonstrated within our analysis, where the PBs modelled recovery through discussing their personal experiences with the YPs. This appears a key, unique, and highly valued foundation of peer support which is unable to be provided by traditional mental health professionals without experiential knowledge (Gidugu *et al.*, 2015; Proudfoot *et al.*, 2012).

The additional mechanisms generated from the email exchanges align with previous peer support research. The provision of psychosocial support has been identified in parallel peer support literature (Gidugu *et al.*, 2015; Proudfoot *et al.*, 2012) and was apparent within the current study as the PBs monitored progress, provided suggestions and advice. This included

encouragement in treatment engagement, development of skills to manage distress and finally practical advice which arose from experiential knowledge. Within the current study, this mechanism also appears to have been extended as the PBs monitored the YPs' progress and made them accountable, which for individuals with an inconsistent support network or who are more independent, has been found to be particularly beneficial (Akey and Rintamaki, 2014). In addition, positive encouragement was frequently used by the PBs. This has previously been identified an essential component of peer support which has a positive impact on quality of life (Bellamy *et al.*, 2017; Davidson *et al.*, 2012). Furthermore, the generation of a safe space through the dyadic interactions disclosing their experiences and modelling this to the YPs has also been highlighted within the peer support literature as a mechanism to support recipients to discuss areas of their life they are struggling with. In an examination of an online ED support forum, it was noted that the online platform created a safe space through a combination of anonymity and the expectation of respect (Kendal *et al.*, 2016). Our aligned findings bolster the current evidence on peer support mechanisms and highlight its potential to be transferred to a range of formats and online platforms.

There are limitations to consider in the study. Though the moderation of the emails was necessary, it may have influenced the findings through modifications to the exchanges, or the dyads' awareness that the emails were being viewed. Additionally, while the data explored was rich due to the length and depth of email exchanges, the small sample size is a major limitation. A larger sample size may have supported the identification of other mechanisms of support potentially observed in different pairings. Furthermore, only a small minority of participants in the peer support service consented to taking part, therefore this analysis cannot be assumed to be representative of all participants receiving the service. In addition, as recognised in the methodology, the authors have experience working within the field of EDs

and are currently involved in evaluating the efficacy of the peer support scheme described. Therefore, there is the potential that they may have entered the analysis with prior assumptions of what to expect from peer support and to its position in supporting individuals with mental health difficulties. Though steps were taken to acknowledge this potential bias, it is important to consider this influence on the findings.

Although not generalisable, the findings provide crucial insights which could be used as case studies for peer support training, evidencing the fundamental platform of lived experience on which peer support is based, and how the role of PB is distinct from being a therapist. This would include consideration of a holistic picture of recovery and a more realistic picture of the recovery process, which would involve normalising relapses and setbacks as a part of this. This may be more pertinent in an ED population where there is a common weight-based recovery narrative within the general population and therefore a need to counteract this.

Further studies could expand upon the current research. Our current study used data from individuals who were engaged with a prolonged peer support relationship and consented to participation. This may potentially lead to a positive bias in our findings and omit underpinning mechanisms of peer support which lead to disengagement, negative effects or indeed harm. Further qualitative analysis of the transcripts of individuals who disengaged from similar services, alongside qualitative interviews with all participants on the impact of peer support, could lead to a more rounded analysis. This should be considered in parallel with ongoing quantitative research exploring the efficacy of peer support programmes within the field of EDs, including impact on service use. Future research into email exchange peer support services should focus on establishing methods to encourage engagement in this research process, potentially via clearer co-production with individuals with eating disorders,

as there may continue to be challenges with participants not wishing to disclose highly personal email exchanges. Furthermore, this study has highlighted the importance of using lived experience to support the development of a personalised and holistic vision of recovery for individuals experiencing an ED. Further research is now required to explore the feasibility and impact of the integration of peer support into traditional ED treatment programmes due to this unique perspective.

The study adds to our understanding of ED peer support and provides a qualitative insight into the peer support provided in an email peer support exchange service. The findings demonstrate how email peer support was provided through mechanisms of positive encouragement, checking in and prompting, defining recovery and creating a safe space underpinned by the relating and reflecting of experience. These mechanisms are aligned with previous findings within peer support research and also highlight an additional mechanism of personalised recovery definition which may be more aligned with a longer term one to one contact, present within email exchanges. The findings could potentially be used as case studies for peer support training, supports consideration of flexibility in the provision and delivery of different platforms of peer support aligned with individual need, and reinforces the benefits of peer support for those with an ED.

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